Arizona Living Light, LLC
www.ronnaprince.com
Confidential Client Information

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information

NAME:_____TODAY'S DATE:_____

ADDRESS:_____

EMAIL ADDRESS: (please print)_____

Home Phone: _____ May we leave a message? Yes No

Cell Phone: _____ May we leave a message? Yes No

Preferred contact (pick one): TEXT___Voice Mail_____Email_____

Date of Birth:_____ Age: _____ Gender: _____

Occupation:_____

Referred by (if any):_____

Are you under the care of a physician for a chronic condition? Yes No

Are you under the care of a licensed mental health practitioner? Yes No

Are you currently taking prescription medications? Yes No

If YES, to any of the above, please provide a brief description:

_____

_____

_____

Describe any health concerns Ronna should be aware of: _____

_____

Please describe what you would like to address in your session(s) with Ronna, listing your goals from most important to least.

_____

_____

_____

Have you participated in coaching, meditation or psychotherapy in the past? If so, please describe briefly including your assessment of the effectiveness of the process.

_____

_____

_____

Which worked best, and why?_____

_____

_____

_____

What do you do to manage stress?_____

_____

_____

What are your most significant concerns about your ability to be successful in a coach-directed program?_____

_____

On a scale of 1-5, How willing are you to incorporate behavioral changes in order to attain the outcome you desire? _____

(1= only slight changes; 2= a few changes; 3= a moderate amount of change; 4= a great deal of change; 5= as many changes as I need to make to ensure permanent success

Life Event Ratings

Please check those events that you have experienced in the past 12 months.

☐ Change in Marital Status ☐ Death or illness of family member or close friend
☐ Retirement ☐ Personal illness or injury ☐ Change of living conditions
☐ Change in recreation/social activities ☐ Change in eating habits ☐ Other major stress: If yes, please describe: _____

Concerns or Interests

☐ Stress/Tension
☐ Low self-esteem
☐ Procrastination
☐ Addictions
☐ Insomnia
☐ Weight Issues incl. binge eating
☐ Communication challenges in relationships
☐ History of childhood abuse
☐ Unresolved Guilt
☐ Depression
☐ Phobias
☐ Fear of attention
☐ Low Energy/Lack of Motivation
☐ Intimacy Challenges
☐ Compulsive Behavior or Thinking
☐ Headaches or other chronic pain
☐ Smoking or other tobacco use
☐ Work Conflict
☐ Unresolved Trauma
☐ Anxiety
☐ Panic attack syndrome
☐ Fears

In the past what have you done to address these issues: _____

_____

_____

_____

What do you consider to be some of your strengths:

_____

_____

_____

What do you consider to be some of your challenges:

Please list any additional information you feel might be helpful in addressing your issue(s):